STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			08/09/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
PPOOKE	DALE PLACE AT FA	II CBEEK II C			ESSLER BLVD EAST IAPOLIS, IN46220		
BROOKL	DALE FLACE AT FA	LL GREEN, LLG		INDIAN			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0000							
	,		-				
	This visit was for	r the Investigation of	RO	0000	The following is the plan of	_	
	Complaint IN000	093579.			correction for Brookdale Plac	ce of	
	•				Fall Creek in regards to the	70	
	Complaint IN000	093579 - Substantiated.			complaint survey IN0009357	79	
	•				conducted on August 9, 2011. This plan of correction	ie	
		s related to the allegation			not to be construed as an	i S	
	are cited at R052	, R091, R214 and R349.			admission of our agreement	with	
					the findings and conclusions		
	Date of Survey:	August 9, 2011			the statement of deficiencies	or	
					any related sanction fine. Ra	ather	
	Facility number:	010064			it is submitted as confirmatio	n of	
	Provider number				our ongoing efforts to comply	/ with	
	AIM number: N				statutory and regulatory		
	Anvi number. N	/A			requirements. In this docum		
					we have outlined specific act		
	Survey Team:				in response to identified issu We have not provided a deta		
	Mary Jane G. Fis	scher RN			response to each allegation		
					finding, nor have we identifie		
	Census bed type:				mitigation factors. We remain		
	Residential: 52				committed to the delivery of		
					quality health care services a	and	
	Total: 52				will continue to make change	es	
					and improvements to satisfy	that	
	Census payor typ	oe:			objective.		
	Other: 52						
	Total: 52						
	Sample: 4						
	Sampic. 4						
	These state finding	_					
	accordance with	410 IAC 16.2-5.					
	Quality review 8	/15/11 by Suzanne					
	Williams, RN	<u>,</u>					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
			ı		I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

010064

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	A. BUILDING 00 COMPL		ETED	
			B. WIN			08/09/2	011
NAME OF F	PROVIDER OR SUPPLIEF		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	ESSLER BLVD EAST		
BROOKE	DALE PLACE AT FA	LL CREEK, LLC		INDIAN	IAPOLIS, IN46220		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEPCIENCT)		DATE
R0052	(1) sexual abuse;	e the right to be free from:					
	(2) physical abuse	2;					
	(3) mental abuse;						
	(4) corporal punis	hment;					
	(5) neglect; and (6) involuntary sec	clusion					
	` '	review, observation and	R	0052	052What corrective action	will	08/31/2011
		cility failed to ensure		7032	be accomplished for those		00/51/2011
	•	ree from physical abuse,			residents found to have be	een	
		dent A wandered into the			affected by the alleged		
		B, resident B pushed			deficient practice? In responsible to this finding, Resident B w		
		fell to the floor and			assessed for continued	as	
	· ·	ured wrist. This deficient			appropriateness of placement at		
					this community through the		
	practice involved	-			resident personal service	lotod	
	residents. [Residents.]	ients A and B _J .			assessment and plan compl by the Health and Wellness		
	Piudius siud de				Director on 8/18/11. Specific		
	Findings include				interventions were added to	_	
	TE1 1.0	· 1 . D			personal service plan and th		
		esident B was reviewed			interventions were documer for care givers via the Care	ited	
		0:15 a.m. Diagnoses			Profile and resident specific		
		re not limited to, senile			assignment sheet. In respo		
		ension and diabetes			to the event itself, Resident		
		diagnoses remained			been referred to the psychia		
	current at the tin	ne of the record review.			specialist serving our comm for evaluation. She has been	•	
					seen at least monthly for se		
		esident was admitted to			months. Medical exam was		
		esident resided on the			completed 7-14-11 (within 2		
	•	wever, as the resident			hours of alleged incident). No recent psych evaluation wa		
	began to display behaviors which included exit seeking, the resident was				completed on August 3, 201		
					with recommendations and		
	moved to the sec	eured dementia unit.			adjustments reviewed with		
					family Resident A was immediately assessed for		
The record also indicated the resid				physical injuries by the nurs	e and		
	been seen by the	psychiatrist for an initial			was sent to the ER for treatr		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE evaluation on 02-07-11 and then had following physician and family notification. She was sent back subsequent visits by the psychiatrist or the with a splint and later casted due nurse practitioner on 04-06-11, 05-04-11, to resident self-removal of splint. 06-08-11, 07-06-11 and 08-03-11. Resident A was observed for any changes of condition and her personal service plan was The initial evaluation indicated the reviewed by the HWD. No resident did not have the potential to changes in care needs were "harm" others. indicated as a result of the fracture, as resident was already receiving the same level of care Further review of the psychiatric notations after the incident as she was prior indicated the resident was observed as to the incident. How will the "quite loud, argumentative and facility identify other residents threatening to staff, sobbing loudly, with the potential to be effected by the same alleged deficient yelling." practices and what corrective The psychiatrist indicated during the action will be taken to ensure 06-08-11 session the resident had the alleged deficient practice dementia with depression and behaviors does not recur? Unit nurse and HWD will audit all current with intermittent outbursts. residents for aggressive behavior However, the 08-03-11 notation indicated in the past 30 days and up date "asked to see for [arrow pointing upward] personal service plans as agitation. Recently pushed peer who had indicated. What measures will wandered into room, breaking peer's be put in place or what systemic changes will the wrist. Can be difficult to redirect." facility make to ensure the alleged deficient practice does The "resident log," dated 07-13-11 at 9:40 not recur? HWD initiated one on p.m., indicated "Res. [resident] had one in-service training with licensed staff immediately to [arrow pointing upward] agitation this assure all understood the policy shift. Family aware." and procedure for abuse prevention and with particular On 08-09-11 at 10:15 a.m., resident A was attention to documentation indicating what specifically was observed wandering throughout the done to protect other residents dementia unit. The resident had a cast on when one resident appears the right arm. During interview on agitated. A staff in-service for 08-09-11 at 10:20 a.m., Certified Nurse Resident Rights and Abuse

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MU5011

Facility ID:

010064

If continuation sheet

Page 3 of 21

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE AT FALL CREEK, LLC (X4)ID SUMMARY STATIMINATOR DIFFICIENCITS REGULATORY OR IS CENTRETIVENOR PROMATION) Aide employee "F" indicated the resident "broke wrist during a fall." Review of the facility provided "Incident Report," on 08-09-11 at 12:00 p.m., indicated the following: "Incident date: 07-13-11, incident time 10:00 p.m., Name of Resident B] bocame agitated and chetred [Name of Resident B] became agitated and shoved [Name of Resident B] became agitated and shoved [Name of Resident] clo [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] to assure [resident] was no longer agitated. [Name of resident B] to a sessed by the residence Geripsych physician. A visual stop aid was places' scice on [Name of Resident B] door to deter wandering residents from entering." During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified Resident A wandered into room. "They're [in reference to the "resident a when Resident A wandered into room." "They're [in reference to the "resident a when Resident A wandered into room." "They're [in reference to the "resident a measure all updates and interventions are included on the service plan and satisfactory." "verified Resident B pushed Resident A wen Resident A wandered into room. "They're [in reference to the resident personal service action will be accomplished for those residents found to have been affacted by the allegad deficient practice?" In response to this finding, Resident a this community through the residence are service.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED
STREET ADDRESS, CITY, STATE, ZIP CODE							08/09/2	011
SOTI KESSLER BLYD EAST NDIANAPOLIS, INAG220				B. WIIV		ADDRESS CITY STATE ZIP CODE	<u> </u>	
BROOKDALE PLACE AT FALL CREEK, LLC NDIANAPOLIS, IN46220	NAME OF I	PROVIDER OR SUPPLIEF	8					
SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PERCEDED BY FULL TAG REGILATORY OR LISE (DESTIFYTING INFORMATION) TAG REGILATORY OR LISE (DESTIFYTING INFORMATION DATE Aide employee "F" indicated the resident "broke wrist during a fall." Prevention is scheduled for August 26 th. During daily staff meetings the HWD. Clare Bridge (Memory Care neighborhood within Brookdale Place) unit manager and Clare Bridge nurse will review any incident reports for aggressive behavior and make the necessary referrals and/or implement appropriate behavior management techniques per individual needs. Individual Resident Gare Profiles will be updated where indicated and copies made available for review by caregivers. How will the corrective actions be monitored to ensure the deficient practice will not recur, Le. what quality assurance programs will be put in place? During monthly Quality Assurance Meetings, the QA committee will review any resident exhibiting aggressive behavior to assure all updates and interventions are included on the service plan and assignment sheets. By what date will these systemic changes be implemented? August 31, 2011 During interview on 08-09-11 at 1:00 p.m., the Health and Wellness Director, employee "A" verified Resident B pushed Resident A when Resident A wandered into room. "They're [in reference to the into room." They're [in reference to the into room." They're [in reference to the into room. They re [in reference to the into room. They re [in reference	BROOKI	DALE PLACE AT EA	II CREEK IIC		I			
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS (PROGULATORY OR LSC IDENTIFYING INFORMATION) (PROGULATORY OR LSC IDENTIFY OR LSC IDENTIFY OR LSC IDENTIFY OR LARGE OF THE AUGUST OR LSC IDENTIFY O						711 OLIO, 114-0220		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE by the Health and Wellness residents and monitor them." Director on 8/18/11. Specific interventions were added to her Review of the facility policy titled "Abuse personal service plan and these Prevention Program Policy," undated, on interventions were documented for care givers via the Care 08-09-11 at 2:00 p.m. indicated the Profile and resident specific following: assignment sheet. In response to the event itself, Resident B had "[Blank] dedicated to the prevention of been referred to the psychiatric resident abuse. The center uses the specialist serving our community for evaluation. She has been following program to ensure every effort seen at least monthly for several is made to prevent abuse. ... 6. Protecting months. Medical exam was residents from any further abuse by B. ... completed 7-14-11 (within 24 2) one on one supervision or emergency hours of alleged incident). Most recent psych evaluation was transfer of any resident suspected or completed on August 3, 2011 allegedly accused of abuse." with recommendations and med adjustments reviewed with Review of the facility policy titled family. . Resident A was immediately assessed for "Abuse, Neglect and Exploitation physical injuries by the nurse and Reporting and Investigation," dated was sent to the ER for treatment. 06-16-2006 on 08-09-11 at 2:00 p.m., following physician and family indicated the following: notification. She was sent back with a splint and later casted due to resident self-removal of splint. "Policy [bold type] Brookdale is Resident A was observed for any committed to maintaining a safe changes of condition and her environment to each resident, visitor and personal service plan was reviewed by the HWD. No associate. Instances or allegations of changes in care needs were abuse, neglect or exploitation should be indicated as a result of the treated seriously and must be reported to fracture, as resident was already the Administrator and or Executive receiving the same level of care after the incident as she was prior Director or the supervisor on duty for to the incident. How will the investigation and appropriate follow-up." facility identify other residents with the potential to be effected "Response to Incident [bold type] - a. by the same alleged deficient practices and what corrective Protection of Resident [underscored].

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Upon learning of alleged abuse, neglect or action will be taken to ensure the alleged deficient practice exploitation, Administrator and or does not recur? Unit nurse and Executive Director or supervisor on duty HWD will audit all current should attempt to take necessary steps to residents for aggressive behavior ensure that residents are protected from in the past 30 days and up date personal service plans as subsequent episodes of abuse, neglect or indicated. What measures will exploitation while a determination on the be put in place or what matter is pending. ... c. Resident on systemic changes will the Resident Contact [underscored] - If an facility make to ensure the alleged deficient practice does incident involves resident on resident not recur? HWD initiated one on contact, both residents should be one in-service training with evaluated for a changed of condition. licensed staff immediately to Residents exhibiting aggressive behavior assure all understood the policy and procedure for abuse should be considered for continued prevention and with particular appropriateness and interventions should attention to documentation be developed to address their behaviors. indicating what specifically was The Resident assessment and Service Plan done to protect other residents when one resident appears should be updated as appropriate." agitated. A staff in-service for Resident Rights and Abuse The facility was unable to provide Prevention is scheduled for documentation the policy was followed in August 26 th . During daily staff regard to the protection of other residents meetings the HWD, Clare Bridge (Memory Care neighborhood from further abuse. within Brookdale Place) unit manager and Clare Bridge nurse This State Finding relates to complaint will review any incident reports for aggressive behavior and make IN00093579. the necessary referrals and/or implement appropriate behavior management techniques per individual needs. Individual Resident Care Profiles will be updated where indicated and copies made available for review by caregivers. How will the corrective actions be monitored to ensure the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CON	STRUCTION	(X3) DATE S COMPLI		
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			B. WING	DEET AD	DDRESS, CITY, STATE, ZIP CODE	00/00/2	
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BROOKE	DALE PLACE AT FA	LL CREEK, LLC	INDIANAPOLIS, IN46220				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
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R0091	(h) The facility sha a written policy macare and facility of attained, to include (1) The range of st. (2) Residents' right (3) Personnel adm (4) Facility operations of the policies shall residents upon record interview, the fact their policy was a when a resident [which resulted in resident to anothen ursing staff failed facility policy released on the resident who disposample of 4. [Reference of the policy was a staff failed facility policy released on the policy of the policy released on the policy of	Il establish and implement anual to ensure that resident opectives are the following: ervices offered. Its. ininistration. Its. ininistration. Its. in the end of a vailable to quest. Its. in that Its played behaviors a physical abuse by one the resident [A], the end to implement the lated to the protection of the rabuse, for 1 of 1 olayed physical abuse in a sident B].	R0091		deficient practice will not rei.e. what quality assurance programs will be put in place During monthly Quality Assur Meetings, the QA committee review any resident exhibiting aggressive behavior to assurupdates and interventions and included on the service plant assignment sheets. By what date will these systemic changes be implemented? August 31, 2011 What corrective action will be accomplished for those resident found to have been affected by alleged deficient practice? In response to alleged incident, Resident B was redirected and monitored by staff to assure the was no further danger of resider resident altercation. In this incidence, the resident was easily redirected and went to bed for the following day for medical evaluation, and subsequently seen as the subsequently seen all t	ts the	08/31/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MU5011

Facility ID:

010064

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00		
			B. WINC	J		08/09/2	011
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP CODE		
					ESSLER BLVD EAST		
BROOKI	DALE PLACE AT FA	ALL CREEK, LLC		INDIAN	APOLIS, IN46220		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	1.0	DATE
		0:15 a.m. Diagnoses			geriatric specialist on August 3 follow-up.	rd for	
		re not limited to senile			ionow-up.		
	1	tension and diabetes			In response to this finding, Resi	ident	
		diagnoses remained			B was assessed by the physicia	n for	
	current at the tin	ne of the record review.			continued appropriateness of		
					placement on the Memory Care	;	
		resident was admitted to			Unit. The resident's personal service plan was updated and		
	the facility, the i	resident resided on the			completed on 8/18/11. Specific		
	second floor; ho	wever, as the resident			interventions were added to her		
	began to display	behaviors which			personal service plan and these		
	included exit see	eking, the resident was			interventions were provided for		
	moved to the sec	cured dementia unit.			givers via the Resident's Care F		
					and resident specific assignmen	ıt	
	The record also	indicated the resident had			sheet.		
	been seen by the	e psychiatrist for an initial			How will the facility identify of	her	
	1	2-07-11 and then had			residents with the potential to b		
	subsequent visit	s by the psychiatrist or the			effected by the same alleged		
	_	er on 04-06-11, 05-04-11,			deficient practices and what corrective action will be taken	4-	
	1 ^	-11 and 08-03-11.			ensure the alleged deficient pro		
	ĺ				does not recur?	······	
	The initial evalu	ation indicated the					
		have the potential to			To assure that no other resident		
	"harm" others.	r			lacking the proper documentation		
					aggressive events, the unit nurs HWD will review incidents for		
	Further review of	of the psychiatric notations			past 30 days and should any of		
		sident was observed as			incidents involve resident to res		
	"quite loud, argu				altercation, the HWD will audit		
		aff, sobbing loudly,			documentation and update the		
	yelling."	arr, socome rounty,			Resident's Personal Service Pla accordingly.	n	
	1	indicated during the			accordingly.		
		n the resident had			What measures will be put in p	lace	
		epression and behaviors			or what systemic changes will t		
	with intermitten	•			facility make to ensure the alle		
		3-03-11 notation indicated			deficient practice does not recu	ır?	
	1 110 wever, the US	5-03-11 Hotation material					

010064

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE "asked to see for [arrow pointing upward] Associates will be re-educated on "How to handle aggressive agitation. Recently pushed peer who had Behaviors" by the HWD/Designee wandered into room, breaking peer's on August 26 th, 2011. During daily wrist. Can be difficult to redirect." staff meetings, the HWD/Designee, Clare Bridge (Memory Care Neighborhood within Brookdale The "resident log," dated 07-13-11 at 9:40 Place) unit manager and Clare p.m., indicated "Res. [resident] had Bridge nurse will audit events [arrow pointing upward] agitation this involving aggressive behavior to shift. Family aware." complete documentation on the Personal Service Plan, Care Profile On 08-09-11 at 10:15 a.m., resident A was and add to assignment sheet where indicated. observed wandering throughout the dementia unit. The resident had a cast on the right arm. During interview on How will the corrective actions be 08-09-11 at 10:20 a.m., Certified Nurse monitored to ensure the deficient practice will not recur, i.e. what Aide employee "F" indicated the resident quality assurance programs will be "broke wrist during a fall." put in place? Review of the facility provided "Incident During monthly Quality Assurance Report," on 08-09-11 at 12:00 p.m., Meetings, the QA committee will review any resident exhibiting indicated the following: aggressive behavior to assure all incident reports are complete "Incident date: 07-13-11, incident time 10:00 p.m. [Name of Resident A] was By what date will these systemic wandering about the memory care unit changes be implemented? and entered [Name of Resident B] room. August 31, 2011 [Name of Resident B] became agitated and shoved [Name of Resident A] telling [resident] to get out of [resident] house. [Name of Resident A] fell ...wrist was swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx [fracture] to right wrist. The two residents were separated and [Name of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLI	E CONS	TRUCTION 00	(X3) DATE : COMPL	
AND TEAN	of connection	IDENTIFICATION NOWIDER.	A. BUILDING			08/09/2	
			B. WING	ET ADI	DRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			SLER BLVD EAST		
BROOKI	DALE PLACE AT FA				POLIS, IN46220		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	١ '	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG	†	redirected. The staff	IAU	-			DATE
		ne of resident B] to assure					
	_	o longer agitated. [Name					
		scheduled to be assessed					
	1	Geripsych physician. A					
		vas places <sic> on</sic>					
	_	ent B] door to deter					
	_	ents from entering."					
	wandering resid	ents from entering.					
	During interview	v on 08-09-11 at 1:00					
		and Wellness Director,					
	1 ~	erified Resident B pushed					
	1 1	n Resident A wandered					
		ey're [in reference to the					
		supposed to separate the					
	residents and mo						
	residents and inc	onnor them.					
	Review of the fa	icility policy titled "Abuse					
		ram Policy," undated, on					
		p.m. indicated the					
	following:	•					
	"[Blank] dedicat	ted to the prevention of					
	resident abuse.	The center uses the					
	following progra	am to ensure every effort					
	is made to preve	ent abuse 6. Protecting					
	residents from a	ny further abuse by B					
	2) one on one st	upervision or emergency					
	transfer of any re	esident suspected or					
	allegedly accuse	ed of abuse."					
	Review of the fe	acility policy titled					
		t and Exploitation					
		nvestigation," dated as					
	Livehorning and II	ivesugation, uateu as					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		COMPL	
			B. WIN				08/09/2	011
NAME OF F	DOMNED OD GUDDI ICA	<u>u</u>	<u> </u>	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	-		5011 KE	SSLER BLVD EA	ST		
BROOKE	DALE PLACE AT FA	LL CREEK, LLC		INDIAN	APOLIS, IN46220			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLA	N OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICI	ENCY)		DATE
		06, on 08-09-11 at 2:00						
	p.m., indicated th	ne following:						
	"Policy [bold typ	aal Brookdala is						
	committed to ma	=						
		•						
		each resident, visitor and						
		ces or allegations of						
	. •	exploitation should be						
	•	and must be reported to						
		r and or Executive						
		upervisor on duty for						
	investigation and	l appropriate follow-up."						
	"Response to Inc	ident [bold type] - a.						
	-	sident [underscored].						
		f alleged abuse, neglect or						
	_	ninistrator and or						
	-	or or supervisor on duty						
		take necessary steps to						
	-	ents are protected from						
		des of abuse, neglect or						
		e a determination on the						
	•	g c. Resident on						
		t [underscored] - If an						
		s resident on resident						
	contact, both resi							
	*	hanged of condition.						
		ting aggressive behavior						
		ered for continued						
		and interventions should						
		address their behaviors.						
	_	dessment and Service Plan						
	should be update	ed as appropriate."						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	MU5011	Facility I	D: 010064	If continuation sh	neet Par	ge 11 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility was unable to provide documentation the policy was followed in regard to the protection of other residents from further abuse. This State Finding relates to complaint IN00093579. R0214 (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident 's condition, or more often at the resident 's or facility 's request. A licensed nurse shall evaluate the nursing needs of the resident. 214 R0214 08/31/2011 Based on record review and interview, the What corrective action will be facility failed to ensure their policy was accomplished for those residents implemented, in that when a resident found to have been affected by the displayed behaviors which included alleged deficient practice? physical abuse to another resident, the In response to alleged incident, Resident B was redirected and nursing staff failed to update the monitored by staff to assure there assessment and service plan for 1 of 4 was no further danger of resident to records reviewed. [Resident B]. resident altercation. In this incidence, the resident was easily Findings include: redirected and went to bed for the night without further incident. Resident was sent to the Med-Check The record for resident B was reviewed the following day for medical on 08-09-11 at 11:00 a.m. Diagnoses evaluation, and subsequently seen by included, but were not limited to, senile geriatric specialist on August 3 rd for dementia, hypertension and diabetes follow-up. mellitus. These diagnoses remained Personal Service Plan and Care current at the time of the record review. Profile were updated on August 18 The initial assessment and service plan th, by the HWD. Plan was reviewed was dated 01-17-11. with family following discussion about medication adjustments.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTI	IPLE CON	STRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	lG	00	08/09/2	
			B. WING			00/03/2	011
NAME OF I	PROVIDER OR SUPPLIE	R	I		DDRESS, CITY, STATE, ZIP CODE		
BROOKI	DALE PLACE AT FA	ALL CREEK LLC			SSLER BLVD EAST POLIS, IN46220		
		STATEMENT OF DEFICIENCIES	1 11				(V5)
(X4) ID PREFIX		NCY MUST BE PERCEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	At the time the r	resident was admitted to					
		resident resided on the			How will the facility identify of	her	
	1	wever, as the resident			residents with the potential to b	e	
	•	behaviors which			effected by the same alleged		
		eking, the resident was			deficient practices and what corrective action will be taken t	ta l	
		cured dementia unit on the			ensure the alleged deficient pra		
	third floor.	cured dementia unit on the			does not recur?		
					To assure that no other residents	may	
	The record also	indicated the resident had			be lacking appropriate intervent	-	
	been seen by the	e psychiatrist for an initial			for aggressive behavior on the	10110	
		2-07-11 and then had			service plan, the unit nurse and		
		s by the psychiatrist or the			HWD will review all current		
	_	er on 04-06-11, 05-04-11,			residents for aggressive behavio		
		-11 and 08-03-11.			the past 30 days and update pers service plans as needed.	sonai	
					service plans as needed.		
	The initial evalu	ation indicated the			What measures will be put in p	lace	
		have the potential to			or what systemic changes will t		
	"harm" others.	r			facility make to ensure the alleg deficient practice does not recu		
					aejicieni pracuce aves noi recu	<i>,</i> .	
	Further review of	of the psychiatric notations			Associates will be re-educated of	on	
		ident was observed as			"Dealing with Residents with		
	"quite loud, argu	imentative and			Aggressive Behaviors" on Augu		
		aff, sobbing loudly,			th, 2011 by the HWD/Designee	, .	
	1	sychiatrist indicated			During daily staff meetings the		
		3-11 session the resident			HWD, Clare Bridge (Memory C	Care	
	_	th depression and			neighborhood within Brookdale	;	
		ntermittent outbursts.			Place)Unit Manager and Clare	aidant	
					Bridge nurse will review any in- reports for aggressive behavior		
	However, the 08	3-03-11 notation indicated			make the necessary referrals and		
		[arrow pointing upward]			implement appropriate behavior		
		ntly pushed peer who had			management techniques per		
	1 -	oom, breaking peer's			individual needs.		
		fficult to redirect."			How will the corrective actions	he	
					monitored to ensure the deficie		
	!						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED
			B. WING			08/09/2011
			P. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER				ESSLER BLVD EAST	
BROOKE	DALE PLACE AT FA	LL CREEK, LLC			APOLIS, IN46220	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE
	·	g," dated 07-13-11 at 9:40			practice will not recur, i.e. wha quality assurance programs wi	
	* ·	Res. [resident] had			put in place?	u ve
	[arrow pointing t	ipward] agitation this			put in place.	
	shift. Family aw	are."			During monthly Quality Assura	nce
					Meetings, the QA committee w	i11
	Review of the fa	cility provided "Incident			review any resident exhibiting	
	Report," on 08-0	9-11 at 12:00 p.m.,			aggressive behavior to assure al	1
	indicated the foll	• .			updates and interventions are	,
					included on the service plan and assignment sheets.	1
	"Incident date: 0	97-13-11, incident time			assignment sheets.	
		ne of Resident A] was			By what date will these systemi	c
		the memory care unit			changes be implemented?	
		-				
	-	ne of Resident B] room.			August 31, 2011	
	-	nt B] became agitated				
	_	ne of Resident A] telling				
	[resident] to get of	out of [resident] house.				
	[Name of Reside	nt A] fellwrist was				
	swollen and [resi	dent] c/o [complained				
	of] pain. Type of	f injury/injuries: fx				
	[fracture] to righ	t wrist. The two				
	residents were se	parated and [Name of				
		redirected. The staff				
	1 -	e of resident B] to assure				
		longer agitated. [Name				
		scheduled to be assessed				
		Geripsych physician. A				
	•	as places <sic> on</sic>				
	1	at B] door to deter				
	-	ents from entering."				
	wanuering reside	ms nom enterng.				
	During interview	on 08-09-11 at 1:00				
	~	and Wellness Director,				
	_	erified Resident B pushed				
		Resident A wandered				
	A WILLI	1 TOSIGOTE / 1 Wallucted				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LDING	00	COMPL 08/09/2	
			B. WIN			06/09/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BROOKI	DALE PLACE AT FA	II CREEK IIC		1	ESSLER BLVD EAST IAPOLIS, IN46220		
					1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ.	DATE
	into room "The	y're [in reference to the					
	·	upposed to separate the					
	residents and mo						
	Review of the fac	cility policy titled					
	"Abuse, Neglect						
	_	vestigation," dated as					
	1 1	06, on 08-09-11 at 2:00					
	p.m., indicated th	·					
		· ·					
	"Policy [bold typ	e] Brookdale is					
	committed to ma	intaining a safe					
	environment to e	ach resident, visitor and					
	associate. Instan	ces or allegations of					
	abuse, neglect or	exploitation should be					
	treated seriously	and must be reported to					
	the Administrator	r and or Executive					
	Director or the su	apervisor on duty for					
	investigation and	appropriate follow-up."					
	"Response to Inc	ident [bold type] - a.					
	Protection of Res	sident [underscored].					
	Upon learning of	falleged abuse, neglect or					
	1 *	ministrator and or					
		or or supervisor on duty					
	1	take necessary steps to					
		ent are protected from					
	1 ^ ^	des of abuse, neglect or					
	_	e a determination on the					
		g c. Resident on					
		[underscored] - If an					
	incident involves	resident on resident					
	contact, both resi						
	evaluated for a cl	hanged of condition.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/09/2011			
	PROVIDER OR SUPPLIER DALE PLACE AT FA		B. WING OG/09/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 5011 KESSLER BLVD EAST INDIANAPOLIS, IN46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	should be considerappropriateness at be developed to a The Resident assistant should be update. Further review of lacked an update. Assessment" or "the physical abust resulted in a physical and documplementation of to discourage fur	ing aggressive behavior ered for continued and interventions should address their behaviors. essment and Service Plan d as appropriate." If the Resident B's record d "Personal Service Service Plan" related to be displayed which sical injury to another amentation of the of preventative measures ther physical outbursts. In the Resident B's record do "Personal Service Plan" related to be displayed which sical injury to another amentation of the of preventative measures ther physical outbursts.						
R0349	on each resident. maintained under employee of the fa responsibility. The (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on observa interview, the fac complete clinical resident [B] displ included physica	ible.	R0349	349 What corrective action will be accomplished for those residen found to have been affected by alleged deficient practice?				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 08/09/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5011 KESSLER BLVD EAST BROOKDALE PLACE AT FALL CREEK, LLC INDIANAPOLIS, IN46220 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Resident B's family and physician the nursing staff failed to document were indeed notified of the incident completed details related to Resident B but that fact the physician was continued behaviors or the notified was not recorded. implementation of monitoring of Resident Documentation of physician B for additional or ongoing abusive acts, follow-up through Med Check visit on 7/14/11 is now on the chart along or complete details related to the with documentation of gero-psych circumstances related to the injury visit from 8/3/11. sustained by Resident B, for 2 of 4 sampled residents. [Residents A and B]. How will the facility identify other residents with the potential to be effected by the same alleged Findings include: deficient practices and what corrective action will be taken to Review of the facility provided incident ensure the alleged deficient practice report on 08-09-11 at 12:00 p.m., does not recur? indicated the following: To assure that no other residents are lacking the proper documentation of "Incident date: 07-13-11, incident time notification of family members and 10:00 p.m. [Name of Resident A] was physicians ,the unit nurse and HWD wandering about the memory care unit will audit all such events for the past and entered [Name of Resident B] room. 30 days and should any other incidents involve resident to resident [Name of Resident B] became agitated altercation, the HWD will assure that and shoved [Name of Resident A] telling there is proper documentation of [resident] to get out of [resident] house. notification of family members and [Name of Resident A] fell ...wrist was physician for any resident displaying aggressive behavior toward another. swollen and [resident] c/o [complained of] pain. Type of injury/injuries: fx What measures will be put in place [fracture] to right wrist. The two or what systemic changes will the residents were separated and [Name of facility make to ensure the alleged resident B] was redirected. The staff deficient practice does not recur? monitored [Name of resident B] to assure During daily staff meetings the [resident] was no longer agitated. [Name HWD, Clare Bridge (Memory Care) of resident B] is scheduled to be assessed unit manager and Clare Bridge nurse by the residence Geripsych physician. A will review any incidents involving visual stop aid was places <sic> on alleged aggressive behavior and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTII	PLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	00	COMPL	
			B. WING			08/09/2	U11
NAME OF 1	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DD 0 01/1					SSLER BLVD EAST		
BROOKI	DALE PLACE AT FA		l IN	IDIANA	APOLIS, IN46220		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
		nt B] door to deter			assure there is proper document of notification of family and	ation	
	wandering reside	ents from entering."			physician		
					physician:		
		esident B was reviewed					
		1:00 a.m. Diagnoses			How will the corrective actions		
	· ·	ere not limited to, senile			monitored to ensure the deficie		
		tension and diabetes			practice will not recur, i.e. wha quality assurance programs wi		
	1	diagnoses remained			put in place?	00	
	current at the tin	ne of the record review.			1 1		
					During monthly Quality Assura		
	At the time the r	esident was admitted to			Meetings, the QA committee w	ill	
	the facility, the r	esident resided on the			review any resident exhibiting aggressive behavior to assure al	11	
	second floor; ho	wever, as the resident			necessary notifications have be		
	began to display	behaviors which			made.	011	
	included exit see	eking, the resident was					
	moved to the der	mentia locked unit.					
					By what date will these systemi	c	
	The "resident los	g," dated 07-13-11 at 9:40			changes be implemented?		
	I -	Res. [resident] had			August 31, 2011		
	1 *	upward] agitation this					
	shift. Family aw						
	The record lacke	ed documentation of the					
		ion displayed by resident					
	B toward anothe						
	2 to ward unforme						
	The record for re	esident A was reviewed on					
		5 a.m. Diagnoses for					
		led, but not limited to,					
		en reduction and internal					
	_	oft hip. These diagnoses					
		t at the time of the clinical					
		i ai me mine of the chinical					
	record review.						
	<u> </u>						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	COMPI		
ANDILAN	OF CORRECTION	IDENTIFICATION NOVIDER.		LDING	00	08/09/2	
			B. WIN			00/09/2	.011
NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE AT FALL CREEK, LLC				1	ADDRESS, CITY, STATE, ZIP CODE		
			5011 KESSLER BLVD EAST INDIANAPOLIS, IN46220				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG				TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE	
	On 08-09-11 at 1	10:15 a.m., resident A was					
	observed wander	ring throughout the					
	dementia unit. T	The resident had a cast on					
	the right arm. D	uring interview on					
	08-09-11 at 10:2	0 a.m., Certified Nurse					
	Aide employee "	'F" indicated the resident					
	"broke wrist dur	ing a fall."					
	Review of the re	sident record indicated					
	the following:						
	"07-13-11 10:00	p.m Res. [resident]					
	found on floor in	n hallway moaning and					
	holding right wri	ist. Res. assist times 2					
		ting upward]. Right					
	wrist bruising/sv	velling. Notified [name					
	of physician] Re	eceived order 3 view right					
	wrist d/t [due to]	pain/swelling. Notified					
	[name of local x						
	[
	The record lacked documentation the						
	resident sustaine	d the injury related to					
	physical abuse displayed by resident B.						
	During interview on 08-09-11 at 1:00						
	p.m., the Health and Wellness Director, employee "A" verified resident B pushed						
		_					
		resident A wandered into					
	1	r're [in reference to the					
		supposed to separate the					
		onitor them." The Health					
		rector confirmed the					
		cumentation the Resident					
	had been monito	ored.					

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	COMP	(X3) DATE SURVEY COMPLETED 08/09/2011		
NAME OF PROVIDER OR SUPPLIER BROOKDALE PLACE AT FALL CREEK, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5011 KESSLER BLVD EAST INDIANAPOLIS, IN46220					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	Prevention Progr	cility policy titled "Abuse ram Policy," and undated, :00 p.m. indicated the						
	resident abuse. following progratis made to preve residents from an one on one supertransfer of any reallegedly accuse. Review of the fa "Abuse, Neglect Reporting and Irrevised 06-16-20 p.m., indicated the "Policy [bold type committed to material abuse, neglect on a sociate. Instartabuse, neglect on the sociate of the social of the so	cility policy titled and Exploitation evestigation," dated as 006, on 08-09-11 at 2:00 ne following:						
	the Administrator Director or the s investigation and "Response to Inc Protection of Re Upon learning of	r and or Executive upervisor on duty for d appropriate follow-up." rident [bold type] - a. sident [underscored]. f alleged abuse, neglect or ministrator and or						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		(X3) DATE SURVEY COMPLETED 08/09/2011				
			B. WIN			00/09/2	UII	
NAME OF F	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP CODE			
BROOKDALE PLACE AT FALL CREEK, LLC			5011 KESSLER BLVD EAST INDIANAPOLIS, IN46220					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		DEFICIENCY)	DATE		
		tor or supervisor on duty						
	_	o take necessary steps to						
		ent are protected from						
		odes of abuse, neglect or						
	-	le a determination on the						
	•	g c. Resident on						
		t [underscored] - If an						
		s resident on resident						
	contact, both residents should be							
	evaluated for a changed of condition.							
	Residents exhibiting aggressive behavior							
	should be consid	lered for continued						
	appropriateness	and interventions should						
	be developed to	address their behaviors.						
	The Resident ass	sessment and Service Plan						
	should be updated as appropriate."							
	"External Reporting/Notification [bold							
	type] - b. Notifying Physician							
	[underscored]. The Administrator and or							
	Executive Director or supervisor on duty							
	should notify the resident's physician if							
	there is an allegation of resident abuse,							
	neglect or exploitation (2) Notification							
	and attempts at notification should be							
	documented in the Resident Log."							
		ng relates to complaint						
	IN00093579.							